TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Sentrix Pharmacy and Discount LLC

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-16-2618-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As the insurance carrier took no action within the 45-day period as required by the applicable regulations, the Pharmacy now seeks payment of the claim in full."

Amount in Dispute: $1,717.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is not a corresponding OVN that addresses the use of this medication. Per protocol, Info Request Letter faxed to provider. Second fax faxed to P.O. 5/5. Despite two attempts and given 48 hrs for each attempt no response received from prescribing provider. Lack of info letter faxed to P.O."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 4, 2016	Amantadine 8%, Amitriptyline 2%, Baclofen 4%, , Gabapentin 5%, Ketoprofen 10%, Versatile Base Cream	$1,717.29	$1,717.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out the guidelines for pharmacy services not subject to a certified network.
3. Neither party submitted an explanation of benefits relevant to the services in dispute.

Issues

1. Were the services in dispute subject to prior authorization?
2. What is the applicable rule and fee guideline that pertains to the services in dispute?
3. Based on applicable fee schedule is payment due?

Findings

1. The respondent submitted documentation to support denial namely a request for information dated May 11, 2016 that states, "Since we have been unable to obtain the information for you necessary to conduct an appropriate review, we are not able to process this medication request." 28 Texas Administrative Code §134.530 (b) states,

> Preauthorization for claims subject to the Division's closed formulary.
>
> (1) Preauthorization is only required for:
>
> (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
>
> (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
>
> (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

Based on the above, no evidence was found to support prior authorization was required. Furthermore, 28 Texas Administrative Code §134.530(g) states,

> Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.
>
> (1) Health care, including a prescription for a drug, provided in accordance with §137.100 of this title is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).
>
> (2) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment guidelines, §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

Pursuant to the submitted documented the Division finds the carrier conducted a prospective review of the services in dispute not a retrospective review as allowed per Division Rules. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.503(c)(1)states,

> The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

(C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection

The total allowable reimbursement will be calculated based on the submitted NDC and reported units as follows:

Date of Service	Prescribed Medication	Units	Amount billed	MAR (AWP) x units x 1.25 + $4.00
January 4, 2016	Amantadine 8%	14 bottles	$348.79	$24.22500 x 14 x 1.25 + $4.00 = $427.94
January 4, 2016	Amitriptyline	4 bottles	$65.60	$18.24000 x 4 x 1.25 + $4.00 = $95.20
January 4, 2016	Baclofen 4%	7 bottles	$256.53	$35.63000 x 7 x 1.25 + $4.00 = $315.76
January 4, 2016	Gabapentin 5%	9 bottles	$538.71	$59.85000 x 9 x 1.25 + $4.00 = $677.31
January 4, 2016	Ketoprofen 10%	18 bottles	$188.04	10.45000 x 18 x 1.25 + $4.00 = $239.13
January 4, 2016	Versatile Base Cream	128 bottles	$319.59	$2.50000 x 128 x 1.25 + $4.00 = $404.00
			Total	$2,159.34

3. The total allowable based on the submitted claims' NDC numbers and units dispensed, is $2,159.34. The requestor is seeking $1,717.29. Pursuant to applicable fee guidelines this amount is allowed.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,717.29.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,717.29 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 25, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.